MONASH University

DEPARTMENT OF EPIDEMIOLOGY & PREVENTIVE MEDICINE

FINAL REPORT

A STUDY OF DOCTORS' VIEWS ON HOW HOSPITAL ACCREDITATION CAN ASSIST THEM PROVIDE QUALITY AND SAFE CARE TO CONSUMERS

for the

AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS

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Executive Summary

This study was commissioned by ACHS in the context of the review of EQuIP Version 3 to determine what doctors working in hospitals want from hospital accreditation. It draws information from 12 focus groups in 6 hospitals involving groups of consultants and Registrars/SRMOs. The focus groups explored a set of questions gathering doctors' views of the value of ACHS EQuIP; their attitude to the need for hospitals to report on safety and quality; the characteristics of such reporting; their view of how ACHS could help doctors provide safe patient care; and doctors' own attitudes to accountability for performance in the context of organisational settings.

Detailed responses are provided in the Report, primarily through extensive quotation of doctors' own comments. This helps the reader appreciate the tone and attitude, as well as the content, of the comments. It is important for the reader to keep in mind the methodological limitations of the study. It was difficult to obtain hospital and doctor participation in the study. This was not unexpected; however, it results in participation by supportive hospitals and doctors who are more likely to be biased **in favour** of the accreditation process and involvement with the conduct of the activities of the hospital, but makes more powerful their criticism.

Several broad themes were evident in the doctors' responses:

- Doctors are generally unaware of EQuIP or are sceptical about it. They see it in terms of preparation for a survey, rather than as an on-going exercise, and as such, as a management exercise or something done by nurses in which they are not engaged.
- While doctors readily accept that hospitals should demonstrate their safety and quality of care, they are concerned about how this should be measured; particularly in chronic conditions and non-intervention care. Furthermore they are very anxious about the interpretation of data with limited sample sizes and absence of risk-adjustment. As a result of these methodological issues they worry about the inappropriate use of the data and gaming.
- Finally they reflect a clash in accountability frameworks. Doctors feel accountable within a professional framework to themselves, the patient and family, their peers and to their profession. Junior doctors also feel accountable to the structure within their clinical unit. These doctors do not feel accountable for their work to the hospital organisational structure in which

they work. This is a significant issue for hospital accreditation, which in intent, structure and process is part of an organisational accountability framework. Hence ACHS EQuIP tends not have legitimacy in the eyes of the doctors, other than to the extent the ACHS could influence local hospital management to provide additional resources (Information Technology and adequate staffing are mentioned)!

The Report identifies a number of implications for ACHS if it chooses to respond to these findings:

- There are a range measurement systems issues that need to be addressed if safety and quality are to be reliably measured and where doctors would be willing to accept them and engage with them. Initiatives such as Clinical Risk Management, that engage doctors and senior managers directly have found favour with doctors in the study that have experienced them. Cross-hospital data collection, such as State based or national clinical registries, has also found favour amongst doctors in the study who have been involved. The cross institutional nature of these measurement systems could raise some challenges to the individual hospital focussed performance standards.
- If ACHS want to influence doctors on the 'shop-floor' it will need to establish legitimacy in the eyes of the doctors. It will need to either develop a strategy for doing this directly or engage with other organisations that do have this legitimacy. In the study it is clear that craft associations and learned Colleges are the bodies that doctors turn to for accountability and influence and these could provide an acceptable indirect vehicle for involving doctors.

Introduction

Doctors' "continuing questioning of EQuIP" is of ongoing concern to the Australian Council on Healthcare Standards. Within the context of the 2-year review cycle of the EQuIP Version 3 program ACHS commissioned Professor Just Stoelwinder in association with Professor John McNeil and Dr Joseph Ibrahim, of the Department of Epidemiology & Preventive Medicine, Monash University, to determine, at its most basic, "what doctors on the shop-floor want from hospital accreditation?" This report presents the findings of this study – responding to a set of study questions and exploring the implications of the broad themes that have been identified.

Study Management and Terms of reference

The study was guided by the Clinician Involvement Working Group (CIWG) of the Board of ACHS, with specific project guidance provided Dr Chris Maxwell and Ms Heather McDonald.

The study was set the following questions:

1. Should health care organisations be required to formally demonstrate the safety and quality of patient care?
2. If so, how? And to whom?
3. If accreditation was compulsory, should this be undertaken by:
    - Government?
    - Independent industry based organisation?
    - Some other body?
4. What are the necessary characteristics of the measures that should be used to accredit health services for clinical safety and quality of care?
5. Is their anything the ACHS should introduce or change to assist clinicians in their provision of safe patient care?

In addition senior clinicians were also to be asked:

6. What do medical practitioners think about the value of ACHS EQuIP for patient care?
7. Are the clinicians aware of the differences between a framework of institutional accountability and the professional model of accountability?
8. Are the clinicians aware that the ACHS EQuIP is based on a framework of institutional accountability? Does this change their view of the ACHS?

In addition to the batch of 5 opening questions junior clinicians were to be asked:

9. What do medical practitioners think about the value of ACHS EQuIP for patient care?

Method

12 focus groups, each of 1-hour duration, were conducted by the principle consultant. Focus groups were drawn from the following hospitals:

John Hunter Hospital, Newcastle
Monash Medical Centre, Melbourne
Prince Charles Hospital, Brisbane,
Royal Darwin Hospital;
Royal Price Alfred Hospital, Sydney
The Alfred Hospital, Melbourne;

In each hospital one focus group of consultants and another of registrars and senior RMOs were conducted. In one hospital, consultants and registrars were mixed together in the two groups.
In all, 34 Consultants and 38 Registrars/SRMOs, covering a wide range of specialties, participated in the focus groups.

All focus groups were recorded, with prior permission of the participants, and transcribed. Each of the members of the study team has reviewed most of the transcripts and independently interpreted the themes and issues arising in them.

Methodological Issues

Why focus groups were chosen

The initial brief for the study envisaged a national survey of 'shop-floor' clinicians. However, the design was constrained by the acknowledged lack of awareness and understanding by doctors and their antipathy towards the EQuIP process. It was predicted that this would lead to a very poor response rate to a mailed questionnaire and, even if doctors responded, there would be problems in assuming a common conceptualization of the underpinnings, dynamics and design options for accreditation. It was therefore decided that focus groups would be the most effective method, within the budget constraints of the study, to gather the required responses from these doctors.
In the event, the difficulty in setting up the focus groups confirmed the appropriateness of this method.

The problem of validity of the information gained

The subjective nature of information gained through focus groups and the clear opportunity for bias must be kept in mind in interpreting the outcome of this study. Doctors were generally recruited into the focus groups by hospital medical administrative staff with support from the CEO and/or Medical Director. On some occasions senior management or medical administrative staff arranged the participants themselves.

The focus group participants are therefore not representative of the population of hospital doctors. Hospitals agreeing to participate are likely to give greater value to the accreditation process. Doctors who agree to participate are more likely to be committed to the organisation and its leadership and/or to the accreditation process. In other words the information gained is likely to be more favourable to accreditation and the issues involved than would be gained from the 'average' hospital doctor. The logistics of establishing focus groups in a variety of jurisdictions limited the survey to larger public hospitals with the infrastructure in place to assist recruiting doctors into the groups. Despite the caveat, the method has provided a window into doctors' views of accreditation and associated issues. It reflects the participating doctors views while not necessarily being representative of all such doctors, It does provide valuable insights for ACHS to consider in contemplating future development of the EQuIP process with the medical 'shop-floor' in mind.

The findings

The section addresses the specific questions tasked of the study. The order is altered to reflect the sequence used in the focus groups. The information gained in the focus groups is provided through selected quotations so that the reader can 'hear' the doctors' views in their own 'voice'. In the subsequent Discussion we address the more general themes identified in the doctors' responses.

Responses to the focus group questions

What do medical practitioners think about the value of ACHS EQuIP for patient care? (Questions 6 & 9)

Consultants' views:

Consultants generally had an awareness of the existence of hospital accreditation and EQuIP. However, this awareness was often vague and the attitude generally skeptical, if not cynical. Some typical responses were:

- *The process is flawed.*
- *Brings back memories of when I worked at McDonalds as a kid, the accreditors would come through and it's worth a lot of money to the guys at the top. It means sprucing up your act, at least for the short term.*
- *I would say that the broad consultants view is that the EQuIP processes don't capture the clinical issue of quality.*
- *Assume it's something like a MOPs type of thing?*
- *Not something we've been involved with at all. Some vague negative energy.*
- *I have heard of it as a concept and it's rather ridiculous.*
- *I think in theory that it's a very good idea, but nothing ever gets done about it in practice very much. In terms of pulling up people who are performing below par or whose services are inadequate or if hospital administration is extremely unsympathetic to the coal face. So it's a very good principle but it doesn't really work.*
- *I sort of see it as a bit of a chore*
- *Certainly as a clinician I've always seen the accreditation process as basically somebody else' job. I don't own that.*
- *And we run AIMS forms here, and I'll return from particularly nasty incident and I'll walk past a sign saying that the hospital's just been accredited for another 3 years – and it's a complete dissonance between that and what I just experienced. And what I just experienced, (is) because the management closed 10 beds.*

They typically see accreditation as a management exercise

- *At the time of accreditation I get a lot of email about it. And then everyone gets thanked for doing it! "What a great job you've done!"*
- *There seems to be great running around and putting up signs - just right for accreditation, "this way to outpatients", you know!*
- *We get warned that the accreditation visit is coming up. We all rush around, we get sent a lot of emails, (inaudible) and it's really part of management and we're kind of tidying things up and we're all standing to attention.*
- *Our feeling is that our objective is to pass and keep the administration management happy, that's kind of our role, rather than saying, this is an opportunity to actually look at what we do.*
- *They (senior doctors) don't like being thrust with bits of paper and being told "Continuum of Care, sign here". "This is what you have to count." I think people who approach doctors, senior doctors, especially like that and apart from the fact they have experience and…take a managerialist approach in private medicine. Doctors do have very strong sense of ownership of the process and I think its very difficult to approach them with the attitude "you have to do it", without engaging people in the design and the importance of all this, right from the outset.*

Or ensuring that the hospital as a 'workshop' meets standards in its infrastructure:

- *And to have the processes and facilities in place that we (the doctor) can do our job properly and provide the public with the care that they deserve and should get. So that's another thing that the Accreditation should do, is that I shouldn't have to worry about minimum standards outside my area. I should have, I should be able to rely on the hospital to provide me with support, and…*

  Absolutely (interjection)

  ..and that's what I rely on the Accreditation. That I don't have to worry that the .. that G___'s got adequate anaesthetic machines, that machine should be of an adequate standard. I don't have to worry that my patients have risk getting an anaesthetic. I can just go in there, do my job, concentrate on the best job I can, knowing that the support structures are in pace and are of adequate standard. That's what I rely on you guys (Accreditation Body) to do! (Consultant)

Or nursing based

- *I wasn't very familiar with the EQuIP Program or ACHS until a couple of year's ago In fact (it) was very much a nursing based quality program in my department. Just out of interest do people (others in the focus group) know the program exists and if so, who's actually been involved in it? Or has it been more something that's been nursing based?*
- *I've heard it mentioned and I've known its been around, but more than that I always thought of it as a nursing based.*

A paper exercise

- *We put up sticky things on the wall. Two weeks before the accreditors come around everyone's going to look hard about how to do the fire safety. I mean those trivial and ultimately damagingly annoying things are done and it becomes a paper exercise.*

A one-off exercise reflected in the survey, rather than an on-going process

- *There is a huge amount of paperwork associated with the whole accreditation process and then it comes down to months of preparation with bits of paper that don't seem to have a lot of relevance to what you're doing, in terms of quality projects. (Consultant)*
- *It's a flurry of activity, in a sense, for the visit and then the pressure is off and it doesn't seem to maintain that sort of momentum (Consultant)*
- *I go through the process every 3-4 years and I've mastered the stuff and its fine. As a process it has no use to me whatsoever, in the sense that I am clearly and utterly focused on what our unit needs to do. I am clearly focused on what goal and outcomes we have to measure to do them all. The clinical indicators that you guys, or ACHS, put up for us, are a waste of the time. (Consultant)*

At least one Consultant saw some benefit!

- *So for me accreditation is a really useful tool to push my agenda of ensuring that standards of teaching aren't cut.*

Registrars and SRMOs' views:

It could be expected that junior medical staff would have less appreciation than consultants of the role of hospital accreditation because of their shorter period of involvement with the activities of a hospital. This was confirmed in the focus groups, although they were very familiar with accreditation of medical training programs by the Colleges and Medical Boards. Many of the reactions were similar to the consultants and a sample of responses follows:

- *No, no I haven't heard of it.*
- *We've been around the public hospital system for a while now and if you're there when it gets accredited then you get lots of emails and flyers and everything.*
- *At the moment, I really don't know much about it all, except that I know its a quality programme to make sure hospitals are up to scratch*
- *I think it's a disaster. The bureaucratisation of medical practice -- which unfortunately is one of the things that you have to be careful (of) in these things.*
- *(A)t a more general level we don't have a big input in it. We don't really link up to quality assurance. We're not really involved, we're just doing day-to-day work.*
- *I've only been involved in the College of Surgeons accreditation.*
- *Most of our contact is through nursing, where the name keeps coming up.*
- *The only problem I see if you have something from the administration, whoever or whatever that is, 'we have to fill out these forms', you have to. 'We have to meet these criteria,'….. That's a waste of time. I think one of the reasons is including the amount of time that you've got which (you) might prefer to spend on patient care rather than paperwork.*

Should health care organisations be required to formally demonstrate the safety and quality of patient care? (Question1)

Consultants and registrars/SRMOs generally supported the notion that hospitals should formally demonstrate (report on) the safety and quality of their care. However, a level of cynicism remained:

- *People, at the end of the day, a customer, or the punter, has to be made to feel that he or she is safe going there, they know what they're doing and they've got the best standards by the best people etc. etc., so somehow you've got to measure all that. (Consultant)*
- *I think ultimately you have to have a transparent system, we're not there right now, we don't have the trust. (Registrar)*
- *I think the community wants…if you looked at the people working in private sector and industry, everything has to be justified and assessed. And I think it's their expectation and hence governments are sort of wanting the health industry to do exactly the same thing, and have a standards program in place. So I think from a community point of view I think we're sort of, we have to sort of be at least seen to be auditing our practices and self-assessing. (Registrar)*

- *Is sounds like a necessary evil to have – if that's not too strong a word. (Consultant)*
- *It depends on what the process involves. If the accreditation had no teeth, didn't change anything, but wasted a lot of hours, man-hours, and that seems like not too good. (Registrar)*
- *(Y)ou have to be seen to be doing it. (Registrar)*
- *Do you want the politically correct answer? (Consultant)*

If so, how? And to whom? (Question 2)

While generally accepting the need for, and inevitability of, reporting on safety and quality, Consultants and Registrars/SRMOs did not have much to contribute on how this should be done. They were, however, more likely to see their professional craft groups as having the necessary knowledge to be appropriate for this role. Some, however, recognized the need for independence in the process. These issues are further canvassed in response to questions 3 & 4 below.

- *I think it's the peer groups and specialty colleges that would better understand how this works, what are the constraints, and how you can redistribute your resources within the limitations, your competence, your levels, style of care, and leave it to the bodies to be responsible for trying to make every other areas of weakness in standards and to deal with any problems that come up within the College, rather having an external body overseeing you and laying standards on somebody else's behalf. (Consultant)*
- *In terms of linking it to Accreditation, simply to ensure that it is going on within the confines and bounds of the individual Societies and groups…. I think to try and put it all under one umbrella is going to be far too difficult. (Consultant)*
- *I think that from my own personal point of view, I think that I would take more notice of the College. I really do. It's a nice feeling to have that piece of paper from your own accredited body. And I would have thought that if those other things were brought in that I would expect that to be driven by the College. (Consultant)*
- *In developing indicators, I think the college has to have a central role. (Consultant)*
- *It's (the College) the only appointed body, which everyone in a particular specialty is going to look to. Otherwise it will become "well we've got this, well, who the hell are they?" (Consultant)*
- *It's a problem, however, with having it entirely run by craft groups, and that is that the public don't trust us anymore. (Consultant)*

- *But the public trust will fall down in two ways. One is if we don't tell them exactly what it is we're reviewing and some sort of result. And doesn't have to be a League Table. And the second thing is if they think that the figures have been cooked between friends. (Consultant)*

If accreditation was compulsory, should this be undertaken by:

- ***Government?***
- ***Independent industry based organisation?***
- ***Some other body? (Question 3)***

Given the above choices, as expected doctors prefer that compulsory accreditation be undertaken by an independent organisation although they are concerned that whoever does it has a deep understanding of the work they do. "Number crunchers", which seems to be code for administrators, are not welcome to do this task! Typical responses were:

- *Accreditation is currently done by an independent industry body – the ACHS. (JUS)*
  That's a medical body – medical?
  (Explains membership of ACHS)
  We'd obviously prefer them to do it rather than Government.
  Because? (JUS)
  Well I think they are more sympathetic and understand the complexities of things.
  (Interaction between JUS and Consultant)
- *I'd be very keen on there being significant physician, I mean clinician, input with practicing people, not just sort of people who may in a past life done something and then now ended up (as an accreditor). (Registrar)*
- *Not people that have no idea about how the way things should run. Not people, you know, not number crunchers. People that, you know, have experience and know what the situation is like. Who actually come in and are able to assess the situation. (Registrar)*

What are the necessary characteristics of the measures that should be used to accredit health services for clinical safety and quality of care? (Question4)

This question animated the doctors more than any of the others. Their responses:

They want them to be 'meaningful' and standardised – current clinical indicators are not seen as meaningful:

- *I think they are the meaningful clinical indicators to measure. Whereas many of those that we currently measure like 'how many people get their chest x-rayed' I suspect it becomes less meaningful. (Consultant)*
- *Well first of all its got to be meaningful, but then, if its meaningful, you've got to be sure that everybody's is doing the same thing. (Consultant)*
- *(W)hen you interpret the data you've got to be sure, you know, that you are 'counting apples – not counting oranges'. (Consultant)*

They need to be risk adjusted:

- *To measure outcomes you have to take into account so many variables, that… the patient mix that you are getting.. and that requires a huge amount of resources, if you are going to get reasonable information, or reasonable results from analysing outcomes – you have to look at a whole stack of different things on the way in, so that you can, so that you can …Make sense of it. (Consultant)*
- *I work in Kidneys, and Kidneys have a longstanding national data monitoring a lot of outcome measures. Governments have become progressively interested in that because you can look at use of that – governments substantially funds that, so it's something for other services to be aware of that maybe central government funding might be available, or become available. But I think then the purpose of going to the individual institution lies in teasing out that data. Factors such the casemix really influence how you get to those outcomes measures. So, although we say we know what indicators to measure, there are other factors on the input side that may modulate those outcomes. So that you need to tease them out on a standard basis. (Consultant)*
- *Well that's what we've been doing, we're trying to do so-called risk adjusted comparisons, and I can tell you it's a very easy thing to roll off the cuff, but to actually do is phenomenally difficult. (Consultant)*

Anxiety about the meaningfulness of the measures, their definition and risk adjustment quickly directs the participants to the use of the data collected. Many related bad experiences of the use of data about safety and quality in hospitals by media and politicians.

- *Is the data being collected to further patient outcomes, or is it being collected for other political reasons, which actually might come back to bite the people who honestly collect the data? (Consultant)*
- *I think we're slightly suspicious of it, you know, because it seems to me the more information you give the more you can be attacked. (Consultant)*

- *I think what medical people are scared of is that by undergoing that process that people will gain access to it; who don't understand the numbers; how they are to be used properly and using it for their own agenda. (Consultant)*
- *It's just, I mean, we've seen it before with other.. you say it's the way the information is used by government bodies, by regulatory bodies and the press. They do not understand the very nature of statistics…. and so misleading information is given to society, which can be very damaging to an individual or a hospital. (Consultant)*
- *If they are being used for a punitive purpose then it makes it very difficult (Registrar)*

Many expressed concern about gaming of the data collection if it was to be used for reporting:

- *Critical performance indicators are only critical performance indicators until they're used as a critical performance indicator at which point they become a number to be fudged. (Registrar)*
- *If you start chasing indicators – see, once you develop the dipsticks, all the work is going to be hanging at the dipsticks. (Registrar)*
- *(B)ecause if I've got to measure that I've got the same mortality as the guy next door to me who is getting lots of referral, whatever, I might turn down some bad cases. Which is what is happening in 99%. I may not get involved in too sick a patient, which is what is happening in lots of practices. So may look at me and say you've got 2% mortality and 5% morbidity and the guy next door to you, so.. (Consultant)*
- *We have sort of standards in emergency medicine which are about as crude as they could come and are not a reflection of any quality. And in some cases, departments can be driven by those standards and have less quality because of it. (Consultant)*

Is their anything the ACHS should introduce or change to assist clinicians in their provision of safe patient care? (Question 5)

Given the low level of support for hospital accreditation amongst clinicians it is not surprising that they were not very forthcoming with suggestions as to how ACHS could support them in providing safe patient care.

Some responses revert to the cynical reaction expressed earlier:

- *There's a lot of management-speak which doesn't really mean anything and one of them is quality assurance. And those terms have always been poorly defined. They get asked at all interviews for jobs and they really don't mean anything. You can be an excellent doctor without having to do little audits on yourself the whole time and you can be a really bad one and*

do audits all the time and pass with flying colours in quality assurance, which is exactly what I mean. (Consultant)

Others make suggestions for processes that are already within the EQuIP framework, while continuing to shy away from comparison and reporting:

- *I mean if you have feedback mechanisms that measure whatever, your work, the quality of your work. Doctor A, B, C of the group each caring for patients group Z is performing on this specific question as good, average, standard, has room to improve, is on the top, is providing best practice… that would happen without any special work to be done during our care would be optimised. And as long as it doesn't turn into a comparison thing.*
- *It's far better to have a minimum standard that people have to achieve and that can be set by international results. And for most things we have what we consider are the normal, the normal range we should be achieving. And that's a lot of it based on the American stuff. And I think if you set that minimum level and you analysed looking at whether you are achieving that, that's fine. But when you start comparing and making a list, that compares all the institutions and then gets published, then that's far more, has far more potential to be damaging. (Consultant)*
- *I guess I'd include figures, auditing you know particular outcomes, and having being reviewed by panels of people that would go through whatever parameters are set. (Registrar)*
- *I think that audit is certainly over the last 2 or 3 years has come in more and has certainly helped our practice, it's helped our treatment of patients and it has helped our development of bigger… it's highlighted things we're doing wrong. So I think it's essential to do, but I think what P___ is saying is good – you've got to keep it simple and perhaps a minimum standard is a sensible first way of doing it... (Consultant)*

A number, reflecting their concern about measurement and reporting suggested that the focus should be limited to assuring process:

- *The Accreditation body should know about the processes and be satisfied that there are appropriate processes. And being, you know, continuing, being evaluated and that they work, or having some sort of outcome. (Registrar)*
- *Yes. So in other words you should know, for example, that our's exists and you should validate that we are attending to it. That we are contributing to the information and receiving feedback and whatever. And equally for other areas within the hospital, that they are contributing to their craft group auditing process and that that's being completed satisfactorily. (Consultant)*

- *I think it would be directly aided by actually establishing what areas doctors do feel some ownership of, particularly senior doctors. And actually trying to get them to decide within those, or best areas, that they feel that they have responsible quality of, and ways that they would like to try and measure that. I feel a bit more the grass roots approach to this would help.*

The most common suggestion related to resources. This included requests for support in obtaining resources to undertake measurement and quality assurance and improvement activities and a request that the accrediting process focus on ensuring adequate clinical and support resources exist for safe clinical work.

Resources for measurement and quality activities:

- *(I)f the resources are put in so that the hospitals can measure some of these things, I think that's a very good thing. Because a lot of hospitals don't have the ability to measure a lot of their outcomes. So that if the accreditation process can improve that, then that is a big plus. (Consultant)*
- *(L)ot more documentation and quality work on top of their clinical work without any extra funding or extra staff and I think that that's why it doesn't work as it should. (Registrar)*
- *Is it also that if you're spending all your time doing paperwork and you're not being paid for it and what have you. (Registrar)*
- *I think we need to have feedback but we don't want to be encumbered with all the paperwork and collecting the data either. But the automated systems that we have, we're all connected to computers and so on. It should be something that can be done by programs and not necessarily…your blood tests, you should be able to get audits of your blood tests. Even practical things like – how many contaminated blood cultures have you ordered? How many discharge summaries have you missed? Or, even feedback on the quality of the discharge summaries. And is this discharge summary useful for the GP or useful for the caring(?) people. That's should all be able to be integrated quite simply and then people get feedback, via email even – "this is what your situation is" and" this is where you sit with the rest of the hospital". If people are getting direct feedback all the time I think you're more likely to change your practice, because you're actually knowing what's going on. But you don't want to be encumbered with what they do, all these things so I can meet the audit deadline. Because there's enough on people's plates as it is. (Registrar)*
- *It's dependant on what your IT resources are, how good your information systems are. And they're poor everywhere (Consultant)*
- *But it's not funded for. So it has to be IT obtainable and I don't think the IT obtainable stuff very well… And it's very difficult to get anything IT obtainable to reflect quality in medicine, even if*

these things don't reflect it appropriately, they reflect something to do with it. (Consultant)

- *We need to be constantly measuring, everything we do. But that doesn't happen by itself, because you burn yourself out trying to get all this stuff. So you need to have that sort of support - IT support, project type officer, audit assistant support. And there's not lack of keenness to actually use that data for improvement. It's just not having the time and the resource to actually pull the data from out of the systems. (Consultant)*
- *Now EQuIP could say that hospitals have to have, say, each division's head of medicine has to identify 20 indicators which have to be measured regularly and which have to show an improvement over time. And if that's clear that that has to be done, then they have to spout the amount of funds. Instead well, we're not going to get it and the physicians are all too busy. (Consultant)*
- *(B)enchmarking, control of quality, accurate data… it's very hard to argue with the necessity of it and they implement it now around the world. But they need huge means when you look into it, like resources. (Consultant)*
- *If you want to measure absolutely everything it would take a huge amount of resources.*
  Whether it would be useful?
  Yes but whether it's useful, that's right. Whether it's going to improve your management of these patients that your aiming for.
  Well, it keeps the administration busy!
  (Laughter)" (Interchange between Consultants)

Adequate clinical and infrastructure resources:

- *It would be good to be able to have a demonstration by the hospital that they have the infrastructure in place or the programs in place to go through, whether it be audits whether it be analysis of their own care in a non-judgemental or confrontational indications of areas and to work up and improve things. That they also have infrastructure for the adequate supervision and training of junior staff and to assure that the workloads were the right levels, supervision was appropriate and so on. As long as there is a way of demonstrating, you know we have done this, or if there are recommendations 'this is how you can go about doing this'. (Registrar)*
- *(W)e're talking about generally whether this is adequately resourced. Our management takes that as a reasonable thing, but there's a lot of the services in this Area, which are very under-resourced and probably shouldn't exist. And I think we are a Camden, every hospital in the State is probably a Camden, a Campbelltown. (Consultant)*

- *(W)e have to accredit the management to actually know that their staffing levels are adequate for the sorts of services they are trying to provide. (Consultant)*

Are the clinicians aware of the differences between a framework of institutional accountability and the professional model of accountability? (Question 7) and:
Are the clinicians aware that the ACHS EQuIP is based on a framework of institutional accountability? Does this change their view of the ACHS? (Question 8)

These questions were not explored directly in the focus groups, but indirectly, mainly though exploring doctors' attitudes to accountability for their work in general and safety and quality of patient care in particular.

Institutional, or organizational accountability is formally reflected in characteristics of bureaucracy. In other words, authority and responsibility is vested by the organisation in roles. Employees are appointed to a role and are accountable within a hierarchy for their performance. Professional accountability derives from the training and socialization of professional workers, which defines accountability at an individual level to the client and the professional body, not to the organisation in which the professional works. The professional has a high degree of organizational autonomy in their role. These are general characteristics of professionals working in organizational settings, but are particularly manifest in hospitals. This theoretical framework provides the basis for these questions as accreditation can be seen to be an organizational control process – mandated by the hierarchy of the hospital to establish accountability of performance by doctors to the organisation. It is the organisation that is accredited – not the doctors.

- *JUS: To whom are you accountable for care?*
  R: To our patients.
  JUS: Anyone else? Anybody else? Anything else?
  R: No." (JUS -- Consultant exchange)
- *Well for us perhaps we have our own clear ideas of what accountability is. Which is for the person lying there or the relative of a patient. It's often clear that they (management) have a totally different expectation or understanding of accountability. (Registrar)*
- *But you go from the individual up to the group of patients, up a hierarchy up to the ward, up to the hospital, up to the state etc. And ultimately you become somehow, you just become part of the machinery and the individual does get lost in that. And in that sort of system where systems take precedence and where populations take precedence and everything is based on population figures and group figures etc, I think the individual is left out. (Registrar)*

- *I mean your own self-monitoring is the most – the shortest feedback loop and the most efficient. Peer review by your immediate colleagues at clinical meetings is the next most tightly focussed. Once you move away from that it loses focus – seriously loses focus. I think that's the drawback of looking into it from some system. (Consultant)*
- *We are consciously aware of that and the quality assurance and monitoring yourself – but, it's a heavily interiorised process, very introspective. How much a sort of a system, a bureaucratically oriented system from the outside can approach that on …, clinical judgement, it's an internalised process. (Consultant)*
- *But you know there are a lot of physicians that will say this is my way and nobody is going to criticise me. (Consultant)*
- *JUS: So are you saying you feel no accountability beyond the individual patient?*
  Uhm.. I don't separate completely, the more you go away the less important is the individual…
  You become a bean-counter then. Like you know, if you're sitting in the city watching what dollars are flowing where. (Registrars and consultants Interchange)
- *JUS: How do you see it working? What happens that gives effect to the accountability?*
  Your own ethics and..
  Yes, morals
  ..morals and ..
  Wanting to do the job properly.
  …wanting to do it properly.
  Being sure, doing everything as well" (Registrars and consultants interchange)
- *I think most clinicians know which the important indicators that they need to check on. That's part of their own internal practice and their good practice. They want to make sure that they don't have too many issues (Consultant)*
- *Well, when you have this framework you have to realise that often when it's been put into place you have an inverted pyramid. You've got a small number of people working at the coal face who are expected to take on increasingly more tasks and are continuingly being monitored, almost like in a socialist state, and an increasing number of bureaucrats who are just sitting there and who have to generate paper work to justify their possible existence in the framework. (Consultant)*

Accountability is conceptualised as going to the Clinical Unit, but rarely further into the hospital:

- *I mean I'm not only accountable to the patient, I'm accountable to the Director of the hospital service, I'm accountable to my own director of the unit, so I'm accountable to lots of people. (Registrar))*
- *JUS: (W)here do you see your accountability?*
  Registrar 1: Our patients.
  Registrar 2: We see it on a pretty individual level day to day. Your patients, your registrar, your consultant, your team.
- *Consultant: There is individual accountability and then there's accountability to that Unit that usually happens in most Units. But are you talking about another degree of accountability again to a higher body.*
  JUS: Well I am, but not instead of – as well as.
  Consultant: Yes, And what would be the perceived benefits of such a thing?
  JUS: Well I'm asking you that. Do you see any?
  Consultant: On a Unit level – discussing it with colleagues with a similar expertise and knowledge base and it can be discussed.
- *(Y)ou're what determines what the result is for the unit, so you're still as accountable to the group as an individual for the patients you directly look after. (Consultant)*

Accountability individual or to the specialist college

- *I don't think the clinicians, well the surgeons that audit, don't own it for the outside accreditation process. They own their own sort of moral ethic of what form of accreditation they need to do, in terms of audit and those sorts of things -- as directed by the College of Surgeons. But no so much in order to make the hospital work, or to prove the hospital is doing the right thing, but more for self-validation. (Registrar)*
- *Well within the specialty I know there is a big push within surgery that your accountability is to your peers – vascular, cardio-vascular, all those sort of things – your peers become Victorian, people who are involved in the same surgery as you, State audits and that sort of thing. That's where people get their validation from now days. (Registrar)*

Discussion

Some broad themes are evident in the focus groups that have implications for ACHS in considering future engagement with clinicians on the 'shop-floor'. These were reported in our Interim Report and are repeated below.

Knowledge about accreditation / EQuIP

Doctors are generally not aware of the EQuIP process or of ACHS. If they are, it is usually because they have been involved in a recent preparation for a survey – described by one as "a flurry of activity".

To the extent that they know about, or understand EQuIP, most think it is a nursing activity, or an activity that vouches for the standards, safety and quality of the non-medical part of the hospital. It is commonly seen as 'a paper exercise' imposed from the top by administration that has little relevance to day to day clinical activities. They also tend to see it only as the survey, not as an on-going activity. On-going quality and safety activities are not identified as part of the accreditation process.

Doctors are more familiar with 'accreditation' in the context of intern accreditation, training post accreditation by Colleges and re-certification by Medical Boards. Interestingly, it seems far less contentious in these domains.

Doctors generally support the concept of public accountability by hospitals for safety and quality – "necessary, but very hard to assess".

Because of the general limited knowledge about EQuIP much of the subsequent exploration has dealt with the more clinically manifest elements of "EQuIP" such as clinical indicators, audit and clinical risk management and 'accreditation' as a more generic concept.

Measurement problems

Doctors express great concerns about a range of problems associated with measuring the safety and quality of clinical work.

The inherent capacity to measure elements relevant to the quality and outcome of clinical activity is recognized as being quite variable across the range of hospital work. Areas involving procedures or surgical interventions are seen as more amenable to measurement. In other areas, particularly those involving interventions in chronic disease, often with multiple conditions, measuring outcome is seen as conceptually problematic – to start with "what are the end points?"

Doctors are very concerned that benchmarking style comparisons properly adjust for variation in risk and complexity. Those that have some experience in this area see

this problem as extremely difficult, if not impossible. They are also concerned about other epidemiological properties of various measurement systems, such as validity, reliability etc.

The lack of resources to do the measuring was commented on frequently. This problem is compounded by the nature of clinical work which does not routinely and systematically generate quality control data. When attempts are made to collect such data it is often undertaken in a sloppy and unplanned fashion. This contributes to the view that measuring quality and safety outcome is just a paper-work exercise imposed on shop-floor doctors from above.

Displacement of goals and gaming

Because of the measurement problem and the alignment of incentives doctors worry that performance measures will lead to displaced goals – chasing the indicator rather than focusing on the patients' interest – ".. you have to be careful of your variables because they are secondary variables and if you focus on them they will damage the thing itself."

They are also concerned about issues of gaming.[1]

Public reporting of quality and safety outcomes

Discussions about measuring clinical outcomes with doctors frequently move quickly to discussions about the use of the data by others. Doctors are generally opposed to public reporting for the following reasons:

- Concern about the limits on measurement outlined above.
- Past adverse experience with media handling of such information.
- Vested agendas of other parties, such as bureaucrats and politicians - "Who does it serve and what do we gain?"

In general they "feel under attack" when this information is disclosed.

Because of the above limits on measurement, the complexity of care and clinical settings, doctors express willingness only to accept external review by peers of very like specialty and experience.

[1] See an instructive and entertaining account in Pitches D, Burls A, Fry-Smith A, How to make a silk purse from a sow's ear—a comprehensive review of strategies to optimise data for corrupt managers and incompetent clinicians. *BMJ* 2003;327:1436–9.

Accountability

The current accreditation process assumes doctors on the shop-floor are accountability within the hospital's hierarchy. Doctors in the focus groups, however, did not perceive high levels of organisational accountability. When asked to rank their accountability for the work they do in the hospital they uniformly place their accountability to their individual patient first and well ahead of others. Some rank the patient's family next, but other their peers, followed by their Unit. Only a few then list the hospital. This orientation is to be expected and is supported by a vast range of organisational literature and research.[2]

Doctors are concerned about individual performance, not the overall hospital performance. When active in auditing (primarily in surgery and procedural areas) they do so "as directed by the College of Surgeons, but not so much in order to make the hospital work, or to prove the hospital is doing the right thing, but more for self-validation."

Involvement in measuring activities

In surgery and procedural areas doctors generally report involvement in audit, but on terms as described above and with concern about measuring problems and lack of resources as also described above.

Those that have had experience with 'clinical risk management' techniques (e.g. root-cause analysis) generally report a positive attitude to it when it leads to 'system' improvements because of active involvement of senior management.

Those that have experience with clinical registries generally report a positive attitude, although still express concern about risk adjustment.

Attitude to system issues

Doctors on the shop-floor focus their attention and effort on the short term (the patient "in front of them"). They generally expect others (clinical leadership and administration) to fix longer-term issues that derive from quality and safety measurement and activities.

[2] See for example Abernethy M.A. and Stoelwinder J.U., The role of professional control in the management of complex organizations. *Accounting, Organizations and Society*, 20(1), 1-17, 1995.

Implications for ACHS

Two major implications derive from the information gained by this study, one to do with the development of measuring systems and the other the establishment of legitimacy of the structure of accountability.

Developing measurement systems

Significant work needs to be done on the development of valid, reliable and accurate measurement systems of the outcome of clinical work. Current EQuIP measurements are seen to be discredited, in part on these grounds.

Various models may need to be applied in various clinical areas because of the varying nature of the work.

Cross-hospital if not cross-national systems are required to gain sufficient numbers of observations for reliable tracking and comparison. Procedural areas of medicine provide the easiest and most relevant area to focus initial efforts because the measurement and data collection problems are easiest (but are still a challenge). The experience with clinical registries provides an insight into how this could be done.

Significant investment in information technology and analytic and data capacity will be required to enable the establishment, maintenance and analysis of these measuring systems.

Establishing legitimacy of measurement and accountability for the quality of clinical work.

The accreditation process is, by its nature, one of organisational accountability. It seeks to define through standards and review internal organisational accountability and external organisational accountability. There is extensive organisational literature about the clash between professional constructs of accountability and these organisational constructs.[3]

ACHS's accreditation process is seen by doctors as an organisational, or managerial, process and lacks legitimacy in their eyes, in terms of measuring their work and accountability for patient care quality and safety. Where these activities are taking place they are legitimised by the doctors in this study as either "self-review" or conducted under the auspices of a professional body – typically the relevant College or specialist Society.

[3] Perhaps best articulated by the American medical sociologist, Eliot Freidson, most recently in *Professionalism: The third logic,* 2001. Chicago:The University of Chicago Press.

ACHS needs to consider its strategy if it wishes to make the EQuIP process relevant to shop-floor doctors to assist them provide quality and safe care to consumers. It needs to consider whether this goal is consistent with the rest of the accreditation framework of accountability, which operates within an organisational management structure and culture. In this context it may be more effective to concentrate on the clinical leadership, rather than the medical shop-floor. If it does want to directly influence the medical shop-floor it needs to decide whether it can do this directly and then develop a strategy to gain legitimacy. On the other hand a more effective approach may be to play a secondary role in support of professional bodies such as the Colleges and specialty Societies that already have clinical legitimacy?

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